

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO CONVERT FUNDING  
FOR GRADUATE MEDICAL EDUCATION IN QUALIFIED TEACHING  
HEALTH CENTERS FROM DIRECT APPROPRIATIONS TO AN AUTHORIZA-  
TION OF APPROPRIATIONS

APRIL 27, 2011.—Committed to the Committee of the Whole House on the State of  
the Union and ordered to be printed

Mr. UPTON, from the Committee on Energy and Commerce,  
submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 1216]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred  
the bill (H.R. 1216) to amend the Public Health Service Act to con-  
vert funding for graduate medical education in qualified teaching  
health centers from direct appropriations to an authorization of ap-  
propriations, having considered the same, report favorably thereon  
without amendment and recommend that the bill do pass.

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## PURPOSE AND SUMMARY

H.R. 1216, a bill to amend the Public Health Service Act to convert funding for graduate medical education in qualified teaching health centers from direct appropriations to an authorization of appropriations was introduced on March 29, 2011, by Representative Brett Guthrie (R-KY), and referred to the Committee on Energy and Commerce.

The purpose of H.R. 1216 is to reduce federal spending, deficits, and debt by repealing mandatory programs with limited Congressional oversight and ensure that Congress prioritize the programs it funds by utilizing the traditional appropriations process.

## BACKGROUND AND NEED FOR LEGISLATION

The Patient Protection and Affordable Care Act contained numerous provisions that contained mandatory spending for public health programs that have been traditionally discretionary in nature. In contrast the health care bill that passed the House, H.R. 3962, contained a division dedicated to public health and workforce issues but programs under that division did not contain mandatory appropriations but rather were authorizations subject to future appropriations.

The federal government is now borrowing 42 cents of every dollar it spends. The current projected deficit for this fiscal year is \$1.6 trillion while national debt has exceeded \$14 trillion. Many that support H.R. 1216 also support the concept of providing graduate medical education training in health centers. However, these funds should first be authorized then separately appropriated. It is this system that allows Congress to prioritize spending on those programs that most deserve funding while ensuring that we control spending to reduce the budget deficit. We can no longer afford to fund new programs without eliminating other spending. Congress can set fiscal priorities by subsequently providing funding through the appropriations process after weighing the relative value of different programs.

## HEARINGS

The Committee on Energy and Commerce held a hearing on draft legislation that became H.R. 1216 on March 9, 2011. The following witnesses testified at the hearing:

- The Honorable Ernest J. Istook, The Heritage Foundation
- Dr. John Goodman, President and CEO, National Center for Policy Analysis
- The Honorable Joseph F. Vitale, New Jersey State Senate

## COMMITTEE CONSIDERATION

H.R. 1216 was introduced by Mr. Brett Guthrie on March 29, 2011, and was referred to the Committee on Energy and Commerce.

On March 31, 2011, the Subcommittee on Health met in open markup session to consider H.R. 1216. Subsequently, the Subcommittee ordered H.R. 1216 favorably reported by a recorded vote of 14–11.

On April 5, 2011, the Energy and Commerce Committee met in open markup session to consider H.R. 1216. Subsequently, the Committee ordered H.R. 1216 favorably reported by a vote of 21–14.

#### COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto.

**COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS  
ROLL CALL VOTE # 21**

**BILL: H.R. 1216**, to amend the Public Health Service Act to convert funding for graduate medical education in qualified teaching health centers from direct appropriations to an authorization of appropriations.

**AMENDMENT:** An amendment by Mr. Green, No. 1, to delay the effective date of the bill.

**DISPOSITION: NOT AGREED TO**, by a roll call vote of 14 yeas to 25 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman			
Mr. Barton		X		Mr. Dingell			
Mr. Stearns		X		Mr. Markey			
Mr. Whitfield		X		Mr. Towns			
Mr. Shimkus				Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush			
Mrs. Bono Mack				Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel			
Mr. Terry		X		Mr. Green	X		
Mr. Rogers		X		Ms. DeGette	X		
Mrs. Myrick				Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy				Ms. Schakowsky			
Mr. Burgess		X		Mr. Gonzalez			
Mrs. Blackburn		X		Mr. Inslee	X		
Mr. Bilbray		X		Ms. Baldwin	X		
Mr. Bass		X		Mr. Ross	X		
Mr. Gingrey		X		Mr. Weiner	X		
Mr. Scalise		X		Mr. Matheson	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Mr. Barrow	X		
Mr. Harper		X		Ms. Matsui	X		
Mr. Lance		X		Ms. Christensen	X		
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley							
Mr. Gardner		X					
Mr. Pompeo							
Mr. Kinzinger		X					
Mr. Griffith		X					

Current as of 03/14/2011

**COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS  
ROLL CALL VOTE # 22**

**BILL: H.R. 1216**, to amend the Public Health Service Act to convert funding for graduate medical education in qualified teaching health centers from direct appropriations to an authorization of appropriations.

**AMENDMENT:** A motion by Mr. Upton to order H.R. 1216 favorably reported to the House, without amendment. (Final Passage)

**DISPOSITION: AGREED TO**, by a roll call vote of 21 yeas to 14 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton				Mr. Waxman		X	
Mr. Barton	X			Mr. Dingell			
Mr. Stearns				Mr. Markey			
Mr. Whitfield				Mr. Towns			
Mr. Shimkus				Mr. Pallone		X	
Mr. Pitts	X			Mr. Rush			
Mrs. Bono Mack				Ms. Eshoo		X	
Mr. Walden	X			Mr. Engel			
Mr. Terry	X			Mr. Green		X	
Mr. Rogers	X			Ms. DeGette			
Mrs. Myrick				Mrs. Capps		X	
Mr. Sullivan	X			Mr. Doyle			
Mr. Murphy				Ms. Schakowsky			
Mr. Burgess	X			Mr. Gonzalez		X	
Mrs. Blackburn	X			Mr. Inslee		X	
Mr. Bilbray	X			Ms. Baldwin		X	
Mr. Bass	X			Mr. Ross		X	
Mr. Gingrey	X			Mr. Weiner		X	
Mr. Scalise	X			Mr. Matheson		X	
Mr. Latta	X			Mr. Butterfield			
Mrs. McMorris Rodgers	X			Mr. Barrow		X	
Mr. Harper	X			Ms. Matsui		X	
Mr. Lance	X			Ms. Christensen		X	
Mr. Cassidy	X						
Mr. Guthrie	X						
Mr. Olson	X						
Mr. McKinley							
Mr. Gardner	X						
Mr. Pompeo							
Mr. Kinzinger							
Mr. Griffith	X						

Current as of 03/14/2011

## COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the oversight findings and recommendations of the Committee are reflected in the descriptive portions of this report, including the finding that reigning in mandatory spending is necessary to avoid a debt crisis.

## STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the performance goals and objectives of the Committee are reflected in the descriptive portions of this report, including the goal that reigning in mandatory spending is necessary to avoid a debt crisis.

## NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 1216 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

## EARMARK

In compliance with clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 1216 contains no earmarks, limited tax benefits, or limited tariff benefits.

## COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

## CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

*H.R. 1216—A bill to amend the Public Health Service Act to convert funding for graduate medical education in qualified teaching health centers from direct appropriations to an authorization of appropriations*

Summary: H.R. 1216 would rescind any unobligated funds that were appropriated by the Patient Protection and Affordable Care Act (PPACA) for health centers to expand or establish programs that provide training to medical residents. The bill also would amend the Public Health Service Act to make funding for future payments to those centers subject to annual discretionary appropriations, and it would authorize the appropriation of \$46 million a year for fiscal years 2012 through 2015 for such payments.

CBO estimates that enacting the legislation would decrease direct spending by about \$195 million over the 2011–2016 period and by \$220 million over the 2011–2021 period. Pay-as-you-go proce-

dures apply because enacting the legislation would affect direct spending.

Assuming appropriation of the specified amounts, CBO estimates that the discretionary spending to implement H.R. 1216 would total \$184 million over the 2011–2016 period.

The bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the federal government: The estimated budgetary impact of H.R. 1216 is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

	By fiscal year, in millions of dollars—													
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2011– 2016	2011– 2021	
CHANGES IN DIRECT SPENDING														
Estimated Budget Au- thority .....	−190	0	0	0	0	−5	−5	−5	−5	−5	−5	−195	−220	
Estimated Outlays .....	0	0	−40	−50	−50	−55	−5	−5	−5	−5	−5	−195	−220	
CHANGES IN SPENDING SUBJECT TO APPROPRIATION														
Authorization Level .....	0	46	46	46	46	0	0	0	0	0	0	184	184	
Estimated Outlays .....	0	37	46	46	46	9	0	0	0	0	0	184	184	

Basis of estimate: For this estimate, CBO assumes that the legislation will be enacted by the end of fiscal year 2011.<sup>1</sup> H.R. 1216 would prevent the Secretary of Health and Human Services from obligating any unobligated funds appropriated by PPACA to health centers to expand or establish programs that provide training to medical residents. By rescinding those appropriated funds, H.R. 1216 would reduce direct spending by \$195 million over the 2011–2016 period and by \$220 million over the 2011–2021 period, CBO estimates.

In addition, CBO estimates that implementing H.R. 1216 would incur discretionary costs of \$184 million over the 2012–2021 period, assuming appropriation of the specified amounts.

#### *Rescission of unobligated funds*

Under current law, the Secretary is authorized to make payments totalling about \$230 million over the 2011–2015 period to health centers to expand or establish programs that provide training to medical residents. CBO expects that funding will enable additional health centers to qualify for payments from Medicare for costs incurred for operating an approved training program for medical residents. CBO estimates those additional Medicare payments under current law will total about \$30 million over the 2012–2021 period.

Enacting H.R. 1216 would rescind any unobligated funds appropriated by PPACA to qualifying health centers to train medical residents. Assuming enactment near the end of fiscal year 2011, CBO estimates that about \$40 million will have been obligated,

<sup>1</sup> If the bill was enacted sooner, or if the pace of obligations was slower than anticipated, some additional unobligated balances may remain at the time of enactment. In that case, the budget authority of the grant program would be reduced by the amount of those unobligated balances, resulting in a corresponding decrease in direct spending.

and that \$190 million would be rescinded by the bill. CBO expects that the Secretary of Health and Human Services will obligate funds for 2012 near the end of fiscal year 2011 and therefore estimates no change in outlays until 2013. CBO also expects that the reduction in funding for training programs would result in fewer programs qualifying for additional Medicare payments. CBO estimates that, as a result, Medicare spending for graduate medical education programs would be reduced by about \$30 million over the 2012–2021 period. In total, therefore, CBO estimates that enacting H.R. 1216 would reduce direct spending by \$220 million over the 2011–2021 period.

#### *Authorized grant funds*

The bill would authorize the appropriation of \$46 million for fiscal year 2012 and \$184 million over the 2012–2016 period for qualifying health centers to expand or establish programs that provide training to medical residents. Based on historical patterns of spending for similar activities, CBO estimates that implementing H.R. 1216 would cost \$37 million in 2012 and \$184 million over the 2012–2016 period, assuming appropriation of the specified amounts.

**Pay-as-you-go considerations:** The Statutory Pay-As-You-Go Act of 2010 establishes budget reporting and enforcement procedures for legislation affecting direct spending or revenues. The changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table. Enacting H.R. 1216 would have no impact on federal revenues.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 1216, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON ENERGY AND COMMERCE ON APRIL 5, 2011

	By fiscal year, in millions of dollars—												
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2011–2016	2011–2021
NET DECREASE (–) IN THE DEFICIT													
Statutory Pay-As-You-Go Impact .....	0	0	–40	–50	–50	–55	–5	–5	–5	–5	–5	–195	–220

**Intergovernmental and private-sector impact:** H.R. 1216 contains no intergovernmental or private-sector mandates as defined in UMRA. By reclassifying funding for teaching health centers, the bill would probably decrease the amount of funds that state and local governments receive to implement programs that provide graduate medical education.

Estimate prepared by: Federal Costs: Stephanie Cameron and Lisa Ramirez-Branum; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Jimmy Jin.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

#### FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.



## ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

## APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

## SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

*Section 1. Converting Funding for Graduate Medical Education Funding in qualified teaching Health Centers from direct appropriations to an authorization of appropriations*

The legislation would amend Section 340H of the Public Health Service Act to convert the direct appropriations for graduate medical education grants for teaching health centers to an authorization of appropriations for these activities. The legislation would rescind the unobligated balances from the amounts already provided.

## CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

**PUBLIC HEALTH SERVICE ACT**

\* \* \* \* \*

## TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

\* \* \* \* \*

## PART D—PRIMARY HEALTH CARE

\* \* \* \* \*

**Subpart XI—Support of Graduate Medical Education in Qualified Teaching Health Centers**

**SEC. 340H. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.**

(a) \* \* \*

(b) AMOUNT OF PAYMENTS.—

(1) \* \* \*

(2) CAPPED AMOUNT.—

(A) IN GENERAL.—The total of the payments made to qualified teaching health centers under paragraph (1)(A) or paragraph (1)(B) in a fiscal year shall not exceed the amount of funds appropriated [under subsection (g)] pur-

*suant to subsection (g) for such payments for that fiscal year.*

\* \* \* \* \*

(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL EDUCATION.—

(1) \* \* \*

(2) FACTORS.—In determining the amount under paragraph (1), the Secretary shall—

(A) \* \* \*

(B) based on this evaluation, assure that the aggregate of the payments for indirect expenses under this section and the payments for direct graduate medical education as determined under subsection (c) in a fiscal year do not exceed the amount appropriated for such expenses as determined **in subsection (g)** *pursuant to subsection (g)*.

\* \* \* \* \*

**[(g) FUNDING.—To carry out this section, there are appropriated such sums as may be necessary, not to exceed \$230,000,000, for the period of fiscal years 2011 through 2015.]**

*(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated \$46,000,000 for each of fiscal years 2012 through 2015.*

\* \* \* \* \*

## **Subpart **[XI]** *XII*—Community-Based Collaborative Care Network Program**

### **SEC. **[340H.]** *340I.* COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.**

(a) \* \* \*

\* \* \* \* \*

## DISSENTING VIEWS

We, the undersigned members of the Committee on Energy and Commerce, oppose the passage of H.R. 1216, a bill to convert funding for graduate medical education in qualified teaching health centers from direct appropriations to an authorization of appropriations. Accordingly, we submit the following comments to express our concerns about this extremely short-sighted and deeply divisive legislation.

### INTRODUCTION AND BACKGROUND

Enacted in 2010, the Patient Protection and Affordable Care Act (ACA)<sup>1</sup> expands access to health care for some 32 million Americans and improves health benefits for millions more who are already insured.<sup>2</sup>

But as valuable as it is, health insurance cannot do everything necessary to make our nation healthy. Even if the ACA makes it possible for virtually everyone to be insured, there will still be a major role for its public health provisions. Moreover, there will be an ongoing need for funding for these public health activities.

“Public health” includes many different things:

- It is working with groups and whole communities to improve health, often more effectively than could be done between a provider and a patient. Fluoridation of water for a town is, for instance, vastly better than simply filling every citizen’s cavities. Exercise programs to prevent obesity are better than having to treat diabetes among people who become obese.
- It is tailoring health insurance and health care to prevent and diagnose disease early rather than simply treating it in its later stages. Immunizations are always better than outbreaks. Screening for hypertension is better than simply waiting for strokes.
- It is providing for safety-net services where the insurance market alone fails to do so. Community health centers, HIV-service providers, and family planning clinics provide care to people who might not otherwise be able to find a provider. Health professions education programs can add to the primary care workforce when the market might produce only specialists. (Such programs will be even more necessary once the insurance expansion provisions of the ACA are implemented.)
- And, least glamorous but crucial, it is the infrastructure of daily disease control and health promotion. Closing down unsanitary restaurants is better than treating food poisoning. Compiling and studying epidemic trends can prevent major waves of disease.

<sup>1</sup>The ACA is comprised of two public laws, P.L. 111–148 and P.L. 111–152.

<sup>2</sup>Letter from Douglas W. Elmendorf, Director, CBO to Speaker Nancy Pelosi (Mar. 20, 2010) (on line at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>).

The case might be made clearer by analogy: No community would be well-served if all its homeowners had fire insurance but there were no fire departments, firefighters, fire hydrants, smoke detectors, or indoor sprinklers. That very well-insured town would still burn to the ground. Insurance is necessary, but it is nowhere near sufficient.

The ACA addresses both approaches, with insurance and with public health. This required going beyond the investments in the law to provide health insurance to also include provisions to make significant public health commitments.

It would be insufficient simply to authorize future appropriations for these activities while providing mandatory spending for coverage initiatives. While the Committees on Appropriations of both the House and the Senate have shown ongoing and great leadership in these public health programs, their budget allocations have been too tight to allow significant new initiatives of these sorts. Consequently, the ACA provides as firm a funding and organizational base for these services as possible—mandatory spending—because they are essential in making insurance efficient and productive and in making the nation healthier.

Among the programs designated for mandatory spending in the ACA is the teaching health center (THC) program.<sup>3</sup> Its purpose is to support the training of individuals who will practice in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, or geriatrics—primary care disciplines where our nation is experiencing significant physician shortages. Training takes place in community-based settings such as community health centers where these health professionals are especially in need.

The THC program is administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS). For FY 2011 through FY 2015, \$230 million in mandatory funding is provided for the program. H.R. 1216 seeks to convert this mandatory funding stream into a program of discretionary spending, subjecting the THC program to the annual and unpredictable appropriations process.

#### TEACHING HEALTH CENTERS ADDRESS NATIONAL PRIMARY CARE WORKFORCE SHORTAGE

With or without health reform, there is little disagreement among experts that our nation faces a dire need for more primary care providers. According to a recent article in the *Journal of the American Medical Association* on this issue, only two percent of all medical students plan a career in general internal medicine.<sup>4</sup> This will hardly meet the needs identified by health professionals. The American Academy of Family Physicians, for example, estimated in 2006 that an additional 39,000 family physicians are needed by 2020.<sup>5</sup> The American Association of Medical Colleges estimates

<sup>3</sup>ACA Section 5508(c).

<sup>4</sup>Hauer KE, Durning SJ, Kernan WN, *Factors Associated with Medical Students' Career Choices Regarding Internal Medicine*, *Journal of the American Medical Association* 2008; 300(10):1154–1164.

<sup>5</sup>American Academy of Family Physicians, *Workforce Reform* (online at <http://www.aafp.org/online/en/home/policy/policies/w/workforce.html>).

that an additional 45,000 primary care physicians will be required by 2020.<sup>6</sup> And the Council on Graduate Medical Education (COGME) stated just six months ago that “there is a shortage of primary care physicians in this country and that shortage is likely to worsen”; and it has recommended that the percent of the workforce that is primary care should increase from 32% to 40%.<sup>7</sup>

Members of Congress on both sides of the aisle agree that we are at a crisis point in addressing this issue.<sup>8</sup> Republicans in particular have been adamant about the need to increase our primary care workforce.<sup>9</sup> Indeed, they have repeatedly made this point in their effort to tear down the ACA, arguing that it makes no sense to expand access to health insurance coverage at a time when we lack an adequate number of primary care physicians to provide services.<sup>10</sup>

The THC program is designed specifically to help address this concern.

Because most graduate medical education (GME) is currently conducted in hospitals, many experts have recommended new channels to train residents in the outpatient setting. The Medicare Payment Advisory Commission (Medpac), for example, has recently suggested that such training include “increase[d] experience in nonhospital settings.”<sup>11</sup> COGME has also recommended that our nation “increase training in ambulatory, community, and medically underserved sites by . . . promoting educational collaborations between academic programs and Federally Qualified Health Centers (FQHCs), rural health clinics, and the National Health Service Corps”, including new methods of funding GME.<sup>12</sup>

The THC program takes these recommendations to heart. Under the program, physician training takes place in community-based settings such as federally qualified FQHCs and community health centers. According to HRSA, although the program is not limited to FQHCs, “evidence has shown that resident physicians who train in FQHC settings are nearly three times as likely to practice in un-

<sup>6</sup>American Association of Medical Colleges, *Physician Shortage to Worsen Without Increases in Residency Training* (online at [https://www.aamc.org/download/150584/data/physician\\_shortages\\_to\\_worsen\\_without\\_increases\\_in\\_residency\\_tr.pdf](https://www.aamc.org/download/150584/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf)).

<sup>7</sup>Council on Graduate Medical Education, *Twentieth Report: Advancing Primary Care* (Dec. 2010) (online at <http://cogme.gov/20thReport/cogme20threport.pdf>).

<sup>8</sup>See, e.g., the comments of Rep. Guthrie made during the full Committee mark up of H.R. 1216: “And I agree, and I think everyone here agrees and I appreciate the bipartisan work that has been done before on the need for more primary care physicians in our health system, the need for more healthcare providers in our health system.” (House Committee on Energy and Commerce, *Business Meeting to Mark Up H.R. 1213 et al.*, 112th Cong., pp. 283–284 (Apr. 5, 2011) (transcript of the proceeding)).

<sup>9</sup>See, e.g., comments by Rep. Pitts during the mark up of H.R. 1217, *a bill to repeal the Prevention and Public Health Fund*: “There is no doubt that we are facing a provider shortage, especially in primary care nursing. . . . I would suggest that if you wanted more funding to go toward training more doctors and nurses, the healthcare law should have contained a section explicitly authorizing that funding.” (House Committee on Energy and Commerce, *Business Meeting to Mark Up HR. 1213 et al.*, 112th Cong., pp. 241–242 (Apr. 5, 2011) (transcript of the proceeding)).

<sup>10</sup>See, e.g., the February 2009 press release of Rep. Burgess in which he states: “What’s the point of all the stress we’ve been going through in Congress to reform the healthcare system if there won’t be enough doctors to go around by the time we’re done? If we’re going to pour our efforts into bettering American healthcare, we need to cover all the bases, instead of doing spot-treatments.” (*Burgess: It’s Time to Do Something about the Looming Doctor Shortage* (online at <http://burgess.house.gov/News/DocumentSingle.aspx?DocumentID=110634>)).

<sup>11</sup>Medpac, *Report to the Congress: Aligning Incentives in Medicare* (June 2010) (online at [www.medpac.gov/documents/Jun10\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun10_EntireReport.pdf)).

<sup>12</sup>Council on Graduate Medical Education, *Twentieth Report: Advancing Primary Care* (Dec. 2010) (online at <http://cogme.gov/20thReport/cogme20threport.pdf>).

derserved settings after graduation. They are 3.4 times as likely to work in a [health clinic], when compared to residents who did not train in health clinics].”<sup>13</sup> This is precisely where the need for such physicians is the greatest. Indeed, according to HRSA, it would take another 16,643 primary care physicians simply to meet the needs of the 65 million people currently living in health professional shortage areas.<sup>14</sup>

#### IMPLEMENTATION OF TEACHING HEALTH CENTERS

In January 2011, HHS Secretary Sebelius announced the first round of grants for 11 teaching health centers to train 50 additional residents, and distributed \$1.9 million for the last three months of this fiscal year. The grants are designed to support a center for five years, in part because it takes several years to complete residency training. The first groups of awards were made to teaching centers in California, Idaho, Illinois, Maine, Massachusetts, Montana, New York, Pennsylvania, Texas, Washington, and West Virginia.<sup>15</sup>

The THC program is only a part of a broader effort under the ACA to bolster the primary care workforce.<sup>16</sup> This package of programs already appears to be having an impact even beyond the direct number of new primary care residents trained. Data from this year’s National Resident Matching Program indicate that U.S. medical students are choosing careers in primary care in greater numbers. Approximately 99% of internal medicine residency slots were filled this year, and some 94% of family medicine residency slots were also filled—the highest fill rate ever for family medicine.<sup>17</sup> The ACA has received much credit for these improvements. According to the executive director for the National Residency Matching Program, “[t]he Obama administration has been trying to funnel money into primary care graduate medical education and we think that in this year’s match we were seeing the results of that.”<sup>18</sup>

<sup>13</sup>HRSA, Bureau of Health Professions, Division of Medicine and Dentistry. Teaching Health Center Graduate Medical Education (THCGME) Program, Announcement Number: HRSA-11-149 (Nov. 29, 2010) (online at <http://www.im.org/PolicyAndAdvocacy/PolicyIssues/Education/Funding/Documents/THC%20guidance.pdf>).

<sup>14</sup>HRSA, *Shortage Designation: HPSAs, MUAs & MUPs* (updated May 28, 2010) (online at <http://bhpr.hrsa.gov/shortage/>).

<sup>15</sup>HHS, *HHS Announces New Teaching Health Centers Graduate Medical Education Program* (Jan. 25, 2011) (online at: <http://www.hrsa.gov/about/news/pressreleases/110125teachinghealthcenters.html>).

<sup>16</sup>See, e.g., ACA Section 3502 (relating to community health teams); Section 5101 (relating to the National Health Care Workforce Commission); Section 5102 (relating to state health care workforce development); Section 5103 (relating to the National Center for Health Workforce Analysis); Section 5204 (relating to public health workforce); Section 5207 and Section 10503(b)(2) (relating to the National Health Service Corps); Section 5301 (relating to primary care training); Section 5402 (health workforce diversity); Section 5403(a) (relating to Area Health Education Centers); Section 5405 (relating to primary care); and Section 10501(I) (relating to rural physician training). Numerous payment and delivery system reforms also will serve to enhance the primary care workforce. (See, e.g., ACA Section 5501 (relating to Medicare bonus payments for primary care providers).)

<sup>17</sup>National Residency Matching Program, *Advance Data Tables: 2011 Main Residency Match* (Mar. 17, 2011) (online at <http://www.nrmp.org/data/2011Adv%20Data%20Tbl.pdf>).

<sup>18</sup>Internal Medicine News, *Interest in Primary Care Builds in Resident Match* (Mar. 17, 2011) (online at [http://www.internalmedicine.com/index.php?id=495&cHash=071010&tx\\_ttnews\[tt\\_news\]=53175](http://www.internalmedicine.com/index.php?id=495&cHash=071010&tx_ttnews[tt_news]=53175)).

## MANDATORY SPENDING

The primary objection to the THC program voiced by Republicans is that they are opposed to its being funded through mandatory spending. Given the program's purpose, its track record of accomplishment to date, and concern about the nation's primary care workforce, this position comes as a great disappointment.

Congress has long recognized the need for financial certainty in supporting medical residency training. In fact, since 1965, the vast majority of resident trainees in this country have been supported by mandatory funding through Medicare's GME program, which provided some \$9.5 billion in support in 2009 alone. This is because training a single resident involves at least a three-year commitment; it takes even more time for an institution to build the infrastructure necessary to support residency training. Republicans have acknowledged the necessity for such ongoing and consistent funding support.<sup>19</sup>

The need for this funding continuity is exactly why support for the THC program should remain mandatory spending. Subjecting the program to the whims of the appropriations process would undermine the ability for any institution to effectively recruit and train their residents. Applicants for THC funding need to know it will be worth the investment to create a program to train residents. And resident trainees need to know they will be able to complete their training over three years. Without the funding to back up these commitments, training programs simply can not operate as we have come to know them.

Thus, HRSA has structured the THC program to be administered within these kinds of parameters. For example, in its program announcement, the agency stated that "although the program period is one year, it is HRSA's intent to fund qualified THC's for the entire five year THC GME program period pending satisfactory performance of awardees and availability of federal funds."<sup>20</sup> Any reduction in this funding would be crippling for those 11 programs that have already made the decision to participate—in consultation with key stakeholders such as teaching hospitals and their boards—based on an expectation that continued funding would be available. Converting the program to discretionary funding will also deter other entities from making the business decisions necessary to expand residency training (e.g., securing commitments from potential partners to agree to train new or additional residents, applying for accreditation if not already part of an eligible consortia, and hiring new faculty) since funding would be subject to the annual appropriations fight.

<sup>19</sup> See, e.g., the comments of Rep. Burgess on this issue made during the floor debate on H.R. 1217, a bill to repeal the *Prevention and Public Health Fund*: "Some of this money is going to go for scholarships, but it sets up a big problem. . . . [S]ome of those same students could receive a scholarship for one year, only to find that the Secretary has bigger and better things to spend it on next year." (Statement of Rep. Michael Burgess, Congressional Record, H2624 (Apr. 13, 2011)).

<sup>20</sup> HRSA, Bureau of Health Professions, Division of Medicine and Dentistry. Teaching Health Center Graduate Medical Education (THCGME) Program, Announcement Number: HRSA-11-149 (Nov. 29, 2010) (online at <http://www.im.org/PolicyAndAdvocacy/PolicyIssues/Education/Funding/Documents/THC%20guidance.pdf>).

In comparing it to the fate of the Children’s Hospital Graduate Medical Education program,<sup>21</sup> Republicans actually underscore the need for mandatory funding for the THC program. Residents currently training under the children’s hospital GME program are now greatly concerned about their ability to continue their training. Ending mandatory spending for the THC program simply place residents in that program in the same position of insecurity that their pediatric resident colleagues now face. Such a step is particularly ill-advised at a time when the demand for primary care physicians is—and will continue to be—high.

Republicans’ opposition to mandatory funding for the THC program is especially ironic given their arguments against mandatory funding for the school-based health centers (SBHCs) construction/renovation program also established in the ACA<sup>22</sup> and in support of H.R. 1214, *a bill to repeal mandatory funding for school-based health center construction*. During the mark up of that bill, Republicans argued that they could not support the construction/renovation program because, in their view, it made no sense to build centers for which there was not adequate physician staffing.<sup>23</sup> While we vigorously and completely disagree with the Republican analysis of how the SBHC construction/renovation program is designed to operate in terms of staffing requirements, we wholeheartedly agree with Rep. Burgess’s statement during the debate over H.R. 1214: “If increasing annual wellness visits for children age 10 to 17 is a priority then increasing the physician workforce should also be a priority.”<sup>24</sup> The THC program is all about just that—making our workforce in primary care a top priority. We believe mandatory spending for the THC program will help ensure that it remains that way.

#### AN ANTI-HEALTH REFORM IDEOLOGICAL AGENDA

In our view, the Republican opposition to the THC program as it is currently structured is without merit. It is difficult to see how opposition could be grounded on the merits of discretionary spending versus mandatory spending or the need to protect Congress’s prerogative to fund or not to fund health programs. Congress, Republicans and Democrats alike, makes those kinds of choices—often difficult choices—all of the time.<sup>25</sup> Moreover, opposition based on

<sup>21</sup>The President’s FY 2012 budget proposal calls for the elimination of mandatory spending for this program. During the Committee mark up of H.R. 1216, Republicans argued that the THC program should be treated similarly. (See House Committee on Energy and Commerce, *Business Meeting to Mark Up H.R. 1213 et al.*, 112th Cong., comments of Rep. Guthrie (p. 283) and Rep. Gingrey (pp. 305–306) (Apr. 5, 2011) (transcript of the proceeding).

<sup>22</sup>ACA Section 4101(a).

<sup>23</sup>See, e.g., comments made to this effect by Reps. Burgess and Blackburn during the full Committee mark up. (House Committee on Energy and Commerce, *Business Meeting to Mark Up H.R. 1213 et al.*, 112th Cong., (Apr. 5, 2011) (transcript of the proceeding).

• Rep. Burgess: You are funding the bricks and mortar . . . and you got no doctor, no nurse.” (pp. 154–155 of transcript of the proceeding)

• Rep. Blackburn: “. . . you can build all sorts of buildings . . . but if there is a shortage, if you do not have enough physicians available to deliver the care, individuals . . . do not end up with access to that care delivery, and you still have a problem.” (p. 221 of transcript of the proceeding)

<sup>24</sup>House Committee on Energy and Commerce, *Business Meeting to Mark Up H.R. 1213 et al.*, 112th Cong., pp. 180–181 (Apr. 5, 2011) (transcript of the proceeding).

<sup>25</sup>For examples of various federal programs that are supported through mandatory spending, see Committee on Energy and Commerce, Democratic Staff, *The Pitts Proposal to Block Mandatory Funding in the Affordable Care Act* (Mar. 9, 2011) (online at: [http://democrats.energycommerce.house.gov/sites/default/files/image\\_uploads/Fact%20Sheet\\_03.09.11.pdf](http://democrats.energycommerce.house.gov/sites/default/files/image_uploads/Fact%20Sheet_03.09.11.pdf)).



the substance of the program runs counter to traditional bi-partisan support for primary care training.

Instead, it appears that H.R. 1216 is simply another component of the Republican effort to disrupt, dismantle, and ultimately destroy the ACA—even those programs that have been funded and are up and running, and even those that make good health policy sense, in or out of the health reform law. What they have not been able to achieve whole cloth,<sup>26</sup> Republicans are now attempting to do piece by piece. H.R. 1216 puts the Teaching Health Centers Program in the frontline of this ongoing assault.

We do not believe this is where the THC program should be. Rather, it should remain exactly where it is—at the forefront of helping to build our national health workforce to ensure that all those in need have access to basic health care services.

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GENE GREEN.



<sup>26</sup> Although the House of Representatives has passed legislation to repeal the ACA, that legislation will not become law since the Senate has defeated the proposal. (H.R. 2 passed the House of Representatives in January 2011 (Congressional Record, H322–323 (Jan. 11, 2011)). The Senate defeated a similar proposal a month later. (Congressional Record S475 (Feb. 2, 2011)).